



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Labour's "Black report" moment?

Citation for published version:

Shaw, M, Dorling, D, Mitchell, R & Davey Smith, G 2005, 'Labour's "Black report" moment?', *British Medical Journal (BMJ)*, vol. 331, no. 7516, pp. 575. <https://doi.org/10.1136/bmj.331.7516.575>

Digital Object Identifier (DOI):

[10.1136/bmj.331.7516.575](https://doi.org/10.1136/bmj.331.7516.575)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

Published In:

British Medical Journal (BMJ)

General rights

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.



Labour's "Black report" moment?

EDITOR—The release of the government's latest report on health inequalities on 11 August was curious.^{1,2} Reminiscent of the covert release of the Black report on August bank holiday in 1980, the report appeared when the minister for public health was on holiday and her deputy unavailable.

Personal trainers

In July 2003 the government stated that there would be an annual report from the Department of Health on health inequality indicators related to the health inequality targets. Nothing appeared for more than two years, although the data that were eventually released had been available for some time,³ and when they did appear it was, conveniently, after the election. Even stranger, the press release for the latest report deflected attention from the key finding of widening inequalities in life expectancy and infant mortality by headlining the 12 "early adopter sites" with their "health trainers."⁴ The minister said, "Many people have difficulty in changing to a healthier way of life... Health trainers are one of the many initiatives in the white paper which will help narrow this gap by supporting people to make healthier choices in their daily lives."⁴

To Labour traditionalists, opposed to victim blaming approaches to health promotion, this may have triggered memories of Conservative minister Edwina Currie admonishing the poor to buy cheap but healthy food. To New Labour, however, it may be grist to the mill.

Shifting goal posts

The circumstances of the release of the report should not be allowed to detract from its main message—that health inequalities, as measured by both spatial differences in life expectancy and socioeconomic differences in infant mortality, have widened. The latest data for life expectancy (2001-3) show that the gap between England as a whole and the fifth of local authorities with the lowest life expectancy has increased, by 2% for males and by 5% for females.

The assessment of trends in health inequalities has not been helped by targets that have had their spatial and social units altered, start dates shifted, and measures changed repeatedly in their short lives. The life expectancy target first mentioned health authorities (which were soon

abolished), then the fifth of local authorities with the lowest life expectancy, and now a "spearhead" group. Curiously, the 12 early adopter sites with their health trainers overlap with (but are not exclusively drawn from) the spearhead group. The spearhead group will (for now) be used to measure progress towards the life expectancy target.

The infant mortality target has likewise been reformulated, as the official measure of social class has changed. Moreover, neither of the targets is a true health inequalities target as they compare the worst off groups with the average for the population as a whole rather than considering the entire distribution.⁵ Indeed, the rapid moving of goal posts seems to have confused the drafters of this report, with 2001, 2002, and 2003 all being described as start dates. In fact, New Labour's health inequality targets were announced in July 2000 in the NHS plan and formalised in February 2001.^{5,6}

Widening inequalities

In opposition Labour consistently promised to implement the recommendations of the Black report and was incensed by the attempt to cover it up 25 years ago, as well as by the similar attempt to suppress the impact of the follow-up report in 1987.⁷

The hushed up release of this report raises fears that the bold statements and unprecedented promises of Labour's first years in power—for example, the pledge to eradicate child poverty within a generation—have now been wholly overtaken by the individualistic rhetoric of behavioural prevention and "choosing health" and its three principles of "informed choice, personalisation, and working together." The linking of the adverse trends in health inequalities with the introduction of health trainers is a prime example of this.

Although the proportion of children living in low income households is a national indicator, the report nowhere mentions measuring, let alone directly tackling, the static or widening inequalities in income and wealth that New Labour has presided over, widening housing wealth inequalities being a prime example.⁸ Perhaps rather than focusing on changing the health choices of millions of people the government should think more about a healthier way to govern

and at last choose to use the tax and benefit systems to curb growing social inequalities in income and wealth.

Mary Shaw *reader in medical sociology*
Department of Social Medicine, University of Bristol, Bristol BS8 2PR

Danny Dorling *professor of human geography*
Department of Geography, University of Sheffield, Sheffield S10 2TN

Richard Mitchell *associate director*
Research Unit in Health, Behaviour and Change, University of Edinburgh Medical School, Edinburgh EH8 9AG

George Davey Smith *professor of clinical epidemiology*
Department of Social Medicine, University of Bristol
George.Davey-Smith@bristol.ac.uk

The complete version of this letter is available at <http://bmj.bmjournals.com/cgi/eleletters/331/7514/419#115362>

MS is funded by the South West Public Health Observatory, RM by the Chief Scientist Office of the Scottish Executive Health Department (SEHD). The views expressed here are those of the authors, not of their respective institutions or funders.

Competing interests: None declared.

1 Department of Health. *Tackling health inequalities: status report on the programme for action*. www.dh.gov.uk/PublicationsAndStatistics/Publications/PolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4117696&chk=OXFbWI (accessed 1 Sep 2005).

2 Dyer O. Disparities in health widen between rich and poor in England. *BMJ* 2005;331:419. (20-27 August.)

3 Shaw M, Dorling D, Gordon D, Davey Smith G. Health inequalities and New Labour: how the promises compare with real progress. *BMJ* 2005;330:1016-21.

4 Department of Health. Health trainers for disadvantaged areas. Press release, 11 Aug 2005. (2005/0285.) www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4117720&chk=j8T/Dk (accessed 1 Sep 2005).

5 *The NHS plan: a plan for investment, a plan for reform*. London: HMSO, 2000.

6 Department of Health. Health inequalities—national targets on infant mortality and life expectancy—technical briefing. Revised 2002. www.dh.gov.uk/assetRoot/04/07/78/96/04077896.pdf (accessed 1 Sep 2005).

7 Berridge V, ed. The Black report and the health divide. *Cont Br Hist* 2002;16:131-71.

8 Shelter. *The great divide: an analysis of housing inequality*. London: Shelter, 2005.

Making prison health care more efficient

The cost may be higher than the price

EDITOR—By focusing on the price of prison health care in the editorial by Awofeso,¹ the *BMJ* has done a major disservice to communities that pay for poor (in both meanings of the word) prison health care in non-fiscal ways.

Cost and price are not interchangeable concepts. The prison is a particular environment that gives access to health care for those who are often excluded in other settings: the price of the care should be set against the cost of its absence.

Degradation of the wider public health—for example, through culturing bloodborne

diseases in prisons with inadequate services to prevent needle sharing—and degradation of public order by the reoffending that follows inadequately addressed forensic mental health problems are costs borne by populations but hardly noticed by criminal justice ministers.

While locking fewer people up may keep us safer from disease, it carries political risks that are difficult to take in democracies. More mechanisation would inevitably reduce the good interpersonal work done by many prison officers: it carries the inevitable risk of increasing the social and health costs of imprisonment.

Governments reward custodial agencies' custodial objectives (not escaping) much better than their care objectives (not reoffending or becoming ill). Until the costs of incarceration as well as its price are measured, the public health will remain threatened by the inadequate resources directed to health care in prisons.

Andrew J Ashworth *general practitioner principal*
Davidson's Mains Medical Centre, Edinburgh
EH4 5BP
andrew.ashworth@lothian.scot.nhs.uk

Competing interests: AJA is a former prison doctor and past chairman of the BMA's civil service committee.

1 Awofeso N. Making prison health care more efficient. *BMJ* 2005;331:248-9. (30 July.)

Europe's initiative and progress should be noted

EDITOR—While it is very useful to be reminded about the need for cost efficiency in prison health services, the importance of effective prison health services to public health in general should also be emphasised. Awofeso did not have the space to underline the public health importance of good prison health in his editorial on making prison health more efficient.¹ His concentration on experience in the United States, the United Kingdom, and Australia also pays insufficient attention to initiatives in Europe.

For example, the World Health Organization's Health in Prisons Project, launched in 1995, now has 10 years' experience in promoting health in prisons and custodial settings.² Thirty two countries of Europe are committed to the project, through their prison health policies, showing a willingness to develop best practice guidance on preventing disease and promoting health in prisons on the basis of evidence and experience.³ The project will hold its 10th annual meeting in London next month. The meeting will review progress so far, the impact of its several consensus papers and policy documents, and the priorities for future action.

All countries are facing the same important public health issues, to which good prison health can make a worthwhile contribution. It is time for a global initiative, so that

all regions of the world can learn from each other in this challenging area of public health.

Alex Gatherer *former honorary visiting fellow*
Green College, Oxford OX2 6HG
alexgatherer@aol.com

Competing interests: AG is a temporary adviser to the WHO Regional Office for Europe's Health in Prisons Project.

More information about the WHO project can be obtained from Lars Moller (LMO@euro.who.int) and www.hipp-europe.org

- 1 Awofeso N. Making prison health care more efficient. *BMJ* 2005;331:248-9. (30 July.)
- 2 WHO Regional Office for Europe. *Health in prisons project*. Copenhagen: WHO, 1995. (www.hipp-europe.org)
- 3 Gatherer A, Moller L, Hayton P. The World Health Organization Health in Prison Project after 10 years: persistent barriers and achievements. *Am J Public Health* (in press).

Preventing severe infection after splenectomy

What about old splenectomies?

EDITOR—Newland et al point out that patients who have had a splenectomy should know the risks, be immunised, and take prophylactic antibiotics.¹ But what should happen for patients who were operated on a long time ago (more than 20 years) who have never had any vaccines and are not having antibiotic treatment? No guidelines exist for such patients.

Stephen Sciberras *senior house officer*
St Luke's Hospital, Malta
steffe@di-ve.com

Competing interests: None declared.

1 Newland A, Provan D, Myint S. Preventing severe infection after splenectomy. *BMJ* 2005;331:417-8. (20-27 August.)

Risk of malaria and meningitis increases with asplenia

EDITOR—The editorial by Newland et al on preventing severe infection after splenectomy deals with the risks of malarial infection and meningitis in asplenic travellers rather cursorily.¹

Asplenia, from whatever cause, is not uncommon. Worldwide travel to malarial areas is probably increasing. Increased risks of *Plasmodium falciparum* malaria in asplenic people, although difficult to quantify, are widely recognised. Fatal outcomes, anecdotally, are increased: I have heard of three people who acquired malaria in west Africa and died. Incidence of meningitis in sub-Saharan Africa, India, and Nepal poses substantial potential hazards.

Asplenic travellers should be advised to avoid travel to high risk malarial areas. People who travel should scrupulously adhere to measures to avoid bites and take appropriate antimalarial prophylaxis. Immediate referral for medical advice is essential should a fever develop. People travelling to areas with a high incidence of meningitis must be immunised with meningococcal ACWY vaccine (quadrivalent polysaccharide vaccine that provides a level of protection against meningococcal disease due to groups A, C, W135, and Y).

Harald M Lipman *medical adviser, travel health clinic*
Number One Health Group, London W1G 9QD
haraldlipman@aol.com

Competing interests: HML is associated with a travel health screening clinic.

1 Newland A, Provan D, Myint S. Preventing severe infection after splenectomy. *BMJ* 2005;331:417-8. (20-27 August.)

Authors' reply

EDITOR—Sciberras asks an important question, as many asplenic patients had surgery at a time when the risks of postoperative infection were even less appreciated than at present. Although most infections do occur in the first two years after surgery, most studies will have patients who have had infections as long ago as 20 years.

At this stage undertaking a course of immunisations is worth while, but whether prophylactic antibiotics are necessary is arguable. In theory they should be given, particularly if there is any evidence of immunosuppression—for example, if the patient is taking steroids—but many patients would find it difficult to understand the need, and compliance is likely to be low. Our policy would be to explain the low level of risk and let the patient have a supply of antibiotics to take if there is evidence of developing infection.

For reasons of space we were not able to give the increased risk of malaria and meningitis the importance it deserves. At a time of increasing travel to far flung and exotic places, the risks should be known to everyone giving travel advice and to the patients themselves. We are all aware of such cases and emphasise the risks to patients who have had a splenectomy.

Adrian Newland *professor*
a.c.newland@qmul.ac.uk

Drew Provan *senior lecturer*
Department of Haematology, St Bartholomew's and the Royal London School of Medicine and Dentistry, London E1 1BB

Steven Myint *editor in chief, Journal of Infection*
The Brae, Dunmow, Essex CM6 1HU

Competing interests: None declared.

Embracing Cicely Saunders's concept of total pain

EDITOR—Dame Cicely Saunders defined the concept of total pain as the suffering that encompasses all of a person's physical, psychological, social, spiritual, and practical struggles.¹ Coyle also wrote that a diagnosis of a life threatening illness jars open a door of awareness,² the same door that, for most of our lives, comfortably allows us to keep thoughts about death in the background.

For many people the opening of this door precipitates a crisis and an acute encounter with great total pain. All of this occurs in the context of a modern society that is ill equipped to handle news of possible death.³ Consequently, after diagnosis of a life threatening or life limiting illness, a patient's close family and friends may deny that their loved one is dying or might die from his or her illness. Additionally, as death is now routinely hidden from social view and medicalised,^{4,5} this medicalisation, which professionalises the rituals of caring for

those who are seriously ill or dying, can result in a situation in which only the physical symptoms are given priority.³

Therefore, after the diagnosis, the patient may be acutely isolated, with total pain at risk of being left untended. Certain aspects of palliative care, such as day care, have much to offer from the point of diagnosis. We urge health professionals, patients, and their families to access or refer to the help that is available from palliative care services—in particular, the day units with well developed support services. Such help must be offered irrespective of whether the diagnosis pronounces the end of life or may yet still offer hope of the resumption of more life, for once the door of mortality is opened, the good life will never be quite the same again.

Chi-Keong Ong *head of research and service evaluation*
p.ong@warwick.ac.uk

Duncan Forbes *chief executive*
Shakespeare Hospice, Shotton,
Stratford-upon-Avon, Warwickshire CV37 9UL

Competing interests: None declared.

C-KO is also associate research fellow at the Centre for Primary Health Care Studies at the University of Warwick Medical School.

- 1 Richmond C. Dame Cicely Saunders. *BMJ* 2005;33:238. (23 July.)
- 2 Coyle N. The existential slap—a crisis of disclosure. *Int J Palliat Nurs* 2004;10:520.
- 3 O'Gorman SM. Death and dying in contemporary society: an evaluation of current attitudes and the rituals associated with death and dying and their relevance to recent understandings of health and healing. *J Advanced Nurs* 1998;27:1127-35.
- 4 Thomas C, Morris SM, Clark D. Place of death: preferences among cancer patients and their carers. *Soc Sci Med* 2004;58:2431-4.
- 5 Clark D. Between hope and dying: the medicalisation of dying. *BMJ* 2002;324:905-7.

Cardiac impairment or heart failure?

What about “cardiovascular insufficiency syndrome”?

EDITOR—As a non-clinical researcher currently engaged in a qualitative study of emotions and coping in chronic heart failure, I welcome Lehman et al's editorial debating the label “heart failure.”¹

At a recent meeting with a group of general practitioners the issues of communication between doctor and patient and the use of the term “heart failure” were the dominant feature. Not only does failure, for patients, mean the end of hope but it also carries pejorative connotations of culpability, particularly against the prevailing public health and health promotion background, which emphasises behaviour and lifestyle in the aetiology of heart disease.

The complexity of heart failure can be viewed in many ways, depending on training and professional experience. Physiologists identify one common component across varieties of heart failure as the inability of the cardiovascular system, as a whole, to maintain an adequate pressure gradient in the circulation. Obviously, many of the causes of this inability lie with the structure and function of the heart itself, but that is not the whole story.

Blame should be deflected away from the heart by using “cardiovascular” as the first element of a revised nomenclature. “Insufficiency” is a suitable generic term for the range of deficits in function of the system currently covered by the label heart failure. The variety and complexity of expressions of this condition indicate that it should be described as a syndrome.

“Cardiovascular insufficiency syndrome” is a fairly accurate description, reasonably comprehensive, and, importantly, can conveniently be abbreviated to a simple acronym, CIS.

J David Mitchell *researcher in health and medical sociology*

Division of Primary Care, University of Liverpool,
Liverpool L69 3GB
j.davidm@liverpool.ac.uk

Competing interests: None declared.

- 1 Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005;331:415-6. (20-27 August.)

“Impairment” is no less alarming or confusing than “failure”

EDITOR—Lehman et al consider the term “heart failure” to be imprecise and confusing, preferring “cardiac impairment.”¹

However, the term “cardiac impairment” is as vague and blurred. It is not more descriptive or less confusing. Impairment also covers a wide spectrum or continuum. Paradoxically, it may not reflect the seriousness of the diagnosis, especially in late stages of heart failure when the prognosis may be more serious than that for many malignancies.

Whatever term is used, doctors can avoid confusion by explaining that failure, like many things in life and medicine, is a spectrum, and it does not mean the end. Also patients should be given time and encouragement to ask questions and air fears and concerns.

Atef Michael *specialist registrar*
Queen's Hospital, Burton on Trent DE15 0AR
a.michael2@ukonline.co.uk

Competing interests: None declared.

- 1 Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005;331:415-6. (20-27 August.)

Changing the name has knock-on effects

EDITOR—Lehman et al suggest calling “heart failure” “cardiac impairment.”¹ As a clinical coder, I bring to your attention that “heart failure” is coded to the ICD-10 (international classification of diseases, 10th revision) code I50.9; the description of this code includes “heart failure, biventricular failure, and cardiac, heart or myocardial failure, not otherwise stated.” However, a diagnosis of “heart impairment” with no further qualifying description sends coders to the code I51.9; the description of this code is “heart disease, unspecified.”

If a change of description of the condition is decided on by clinicians, please would they consider informing their clinical coding departments of the change? If coding departments were not informed, the codes applied to the condition might well

alter with the change of name, even though the condition itself stayed the same.

Catie Gilbert *clinical coder*
Clinical Coding Department, West Suffolk Hospitals
NHS Trust, Bury St Edmunds, Suffolk IP33 2QZ
catie.gilbert@wsh.nhs.uk

Competing interests: None declared.

- 1 Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005;331:415-6. (20-27 August.)

What do patients really think?

EDITOR—The editorial by Lehman et al debates renaming heart failure.¹ We agree from our research that many patients do not understand what the term heart failure means. We believe that it would be a shame to substitute the word “heart” with “cardiac”: this may cause more confusion as many patients may not know what the word cardiac means.

We interviewed 40 patients from around the country at different stages of heart failure, and many of them discussed their confusion about the meaning of heart failure—several said that the word failure was unhelpful (these interviews can be seen on www.dipex.org/heartfailure).

Before officially renaming, it might be helpful to have a wider debate about this and ask patients for their opinions.

Kate H Field *senior qualitative researcher*
kate.field@dphpc.ox.ac.uk

Ann McPherson *part time lecturer*
Department of Primary Care, University of Oxford,
Oxford OX3 7LF

Competing interests: Both authors have done research on heart failure in 2003 for DIPEX, University of Oxford.

- 1 Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005;331:415-6. (20-27 August.)

Time for total political correctness?

EDITOR—Lehman et al point out that the term “cardiac failure” is less than helpful. It confuses doctors and it demoralises patients.¹ Cardiac impairment may be, as they suggest, “kinder, and more accurate.”

It is still not quite in tune with the politically correct culture of the past couple of decades.² We would suggest a more appropriate, and current, term, “cardiac deferred success.” It really implies no blame to anyone: much better.

Bernard A Foëx *consultant in emergency medicine and critical care*
bernard.foex@mmc.nhs.uk

Simon Carley *locum consultant in emergency medicine*
Department of Emergency Medicine, Manchester
Royal Infirmary, Manchester M13 9WL

Competing interests: None declared.

- 1 Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005;331:415-6. (20-27 August.)
- 2 Michel T. The guide to politically correct cardiology. *J Irreproducible Results* 1993;39(6):7-8.

bmj.com

Letters appearing here are an edited selection of rapid responses originally posted on bmj.com

We ask for all letters to the editor to be submitted as rapid responses via bmj.com

For advice see: bmj.com/rapidresponses